

Next Steps for the Working Groups: Recommendations for Future Work

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Introduction

The Working Group process has resulted in the creation of a vision for the Iraqi Health Sector. The vision was produced as a result of a consultative consensus process, which included key stakeholders in the Iraq Health Sector. This document attempts to take the vision one step towards implementation by outlining some of the activities which need to take place. Three objectives were identified for the different suggested activities as follows:

1- Generating evidence and information

Effective health planning and implementation require information about the functioning of the various aspects of the health sector. Therefore, the document describes some of the information and research, which should be generated in order to feed into the policy development and implementation process.

2- Developing standards and guidelines

There are standards and guidelines, which must be established prior to developing specific plans for the various aspects of the health sector.

3- Developing plans for implementation

Specific plans need to be developed for the different aspects of the health care that outline how the transitions and developments are to take place.

Finally, the implementation of policies and plans requires the cooperation of many public entities and in some cases the private sector. This means that there should be a strategy for coordinating activities between the MOH and other entities. Therefore, this document also refers to coordination needs.

Type of activity / Working Group	Generating evidence and information	Developing guidelines and standards	Developing plans for implementation	Coordination needs
Public Health	Conduct a study of the burden of disease in Iraq	Develop standards and performance targets for public health	Develop an integrated plan of population-based public health programs Develop strategies for the implementation of national programs focusing on the health of women,	Coordinate with the Ministry of Environment

			<p>infants and children under a decentralized health care delivery system</p> <p>Develop a plan for the implementation of a sustainable General Practice system</p>	<p>Coordinate with the Ministry of Higher Education</p>
Health Finance	<p>Prepare National Health Accounts for Iraq</p> <p>Conduct a survey of household health expenditures and health care utilization</p> <p>Conduct facility- based costing studies</p>	<p>Reach consensus among stakeholders concerning key characteristics of the health financing reform. To some extent, this has been achieved through the early meetings of this Working Group.</p>	<p>Develop a strategy for implementation of the recommended health financing reforms. (Included in the document)</p>	<p>Coordinate with Ministry of Finance, and the Statistics Department of the Ministry of Health</p>
Human Resources	<p>Assess current health manpower, their skills and geographic distribution</p> <p>Survey medical staff to identify expectations and motivational factors to recommend strategies for equitable distribution of human resources geographically and to be able to motivate staff.</p>	<p>Develop norms and standards for human resources needs and distribution</p>	<p>Develop an implementation strategy for Human Resource Development</p>	<p>Coordinate with Ministry of Higher Education, Ministry of Labor, and Ministry of Finance</p>

	Develop a Health Manpower Database: information on gender, age, qualifications, skills, experience, and geographic location.			
Education and Training	Investigate current situation, including the availability and distribution of universities and medical institutions. (Admission criteria to universities and curricula should also be included)	<p>Develop measurable and fair criteria for admissions into universities and technical schools; and also graduation criteria for all medical and health academic programs.</p> <p>Set criteria for nursing education programs under the university system, which combine theoretical education with practical clinical experience.</p> <p>Recommend the implementation of education programs, which correspond to the new public health and health care delivery model.</p>	<p>Develop a plan for the implementation of continuing education programs to strengthen the skills of the medical and paramedical staff.</p> <p>Develop a proposal of options for an independent entity to perform licensing and credentialing functions for all medical and paramedical staff.</p>	Coordinate with Ministry of Higher Education, Ministry of Health, Ministry of Finance, and the Licensure and Accreditation entity.

This document describes detailed next steps for only two Working Groups where significant activities were identified. “Strategy For Implementation” in Annex 2 is not limited only to the Health Financing Working Group, as it takes a comprehensive approach to what needs to be done to start the implementation process.

Annex 1. Public Health Working Group

Activity 1: Prioritization of diseases and risk factors and choosing interventions

1) Rationale

- In order to improve health system performance, limited health resources must be allocated to tackle those diseases which bring the greatest burden (measured by DALY) to the population
- A disease burden study, which ranks all diseases according to their total burden to the population, is an essential step for health planning and resources allocation.
- In order to make best use of resources, the priority diseases and risk factors must be tackled with priority interventions chosen, based on the cost-effectiveness ratios of alternative interventions.
- Choosing cost-effective interventions is another essential step for health planning and resource allocation, and also an important step for the design of the essential benefit package of the national health insurance program.

2) Approaches

- Organize a task group for the disease burden study consisting of technical staff from MOH, university professionals (epidemiologists), and international consultants.
- Undertake a 5-day workshop, with members of the taskforce included as participants.
- Develop a full plan for the disease burden study, which is expected to deliver the following results:
 - Full rank of diseases according to the total burden of each disease on the people of Iraq, and identification of priority diseases that bring about the majority of the burden (based on disease burden study).
 - A list of cost-effective interventions dealing with the prioritized diseases (based on international results of cost-effectiveness analysis of various health interventions).
- Implement the study plan and deliver results in a period of no more than 12 months.

3) Technical assistance:

Given the technical nature of this activity, substantial technical assistance is needed. It will include 1-2 burden of disease experts running the workshop, as well as experts in the field to actually perform the study in collaboration with local professionals.

Activity 2: Development of an integrated plan of population-based public health programs

1) Rationale:

- Population-based public health interventions are proven cost-effective measures for the improvement of population health.
- Most of these interventions cannot be integrated into the clinical health care delivery system, and the role of government should be strengthened in both financing and delivery of these interventions.
- These interventions need to be packaged in order to reduce costs and improve efficiency.

2) Approaches:

- Organize a task group consisting of members of the Public Health Directorate of MOH, health professionals from CDC/Baghdad, and international consultants.
- The task group should list all population-based public health interventions that are being, or will be, delivered.
- Group them according to the means of interventions and the target populations.
- Package interventions in a way that the interventions can be delivered by similar means to similar target populations, so that interventions in the same package can be included in the same program, regardless of the specific objectives of these interventions.
- Design integrated programs of population-based public health interventions in a time period not to exceed 6 months.

3) Technical assistance:

- Short-term assistance from an international expert in the design and implementation of integrated population-based public health programs. Assistance will include review of the international models and experience, and performing field instructions.
- Longer term technical assistance for performing the above activities in collaboration with local team members.

Activity 3: Development of public health standards and performance targets

1) Rationale:

- Public health interventions must be performed according pre-established standards and against pre-set performance targets to achieve the best public health results.
- Standardization covers not only how public health interventions are performed, but also the minimum level of measurable results that can assure the health of the population. It covers a wide range of public health factors, such as noise, quality of drinking water, food production and sale, immunization, and antenatal care, etc.

- Targets reflect the levels of results of public health interventions that are practically attainable, while working towards the ultimate achievement of the pre-established standards.
- Public health intervention targets can be used for the evaluation of public health intervention providers.

2) Approaches:

- Organization of a task group consisting of representatives from all areas of public health (eg., food hygiene, labor hygiene and occupational health, environmental hygiene, maternal and child health, etc.)
- The task group is then divided into several sub-groups according to the technical components of public health, which will then work independently and meet with other sub-groups frequently to propose standards and targets.
- The standardization process will involve the review of international experience and standards, and the setting of the targets will need a full understanding of the current situation in Iraq.
- The estimated time for production of major standards and targets is 12 months, depending on what have been pre-existent in Iraq.

3) Technical assistance:

- International technical assistance should be maintained at minimum level, because much of the work has to be performed by local health professionals.
- A short-term expert is needed to gather international information and review international experience.
- There may be a need for a group coordinator to facilitate the whole process and the activities of sub-groups.

Activity 4: Development of strategies for the implementation of national programs focusing on the health of women, infants and children under a decentralized health care delivery system

1) Rationale:

- Women, infants and children are vulnerable populations, and the promotion and restoration of their health are often addressed through national programs in both developed and developing countries.
- The transition from a centralized health system to a decentralized one in Iraq provides these programs with both opportunities and challenges, which must be explicitly addressed through the reconsideration and redesign of these national programs for the achievement of desirable results.

2) Approaches:

- Organize a task group consisting of both local and international experts working on maternal and child health and reproductive health.

- The task group will review international experience on the impacts of decentralization of health care delivery on the national programs related to the health of women, infants and children, as well as the effectiveness of mitigation measures for strengthening these programs.
- Based on the review of international experience, the group will have to predict the possible opportunities and challenges from the evolution of Iraqi health care system and develop strategies to best assure the successful performance of these programs

3) Technical assistance:

- Technical assistance is needed for the review of international experience.
- An expert may be needed to facilitate the working process of the task group.

Activity 5: Development and implementation of a sustainable General Practice system

1) Rationale:

- General Practitioners (GPs) serve as the backbone of the primary health care system, and the sustainable primary health care system will need a sustainable team of GPs.
- The main problem in Iraq is that General Practice is not seen as a profession, but as a transitional stage towards specialization. This has led to an unsustainable team of GPs in terms of both quantity and skills, and inflated number of specialists.

2) Approaches:

- Organize a task group consisting of health officers from MOH, officers from the Ministry of High Education responsible for medical education, and international experts with good understanding of General Practice systems in Western Europe.
- It is proposed that, over several meetings, the task group will discuss the current problems, define the roles of GPs, and generate strategies for achieving the desirable results.
- Based on the above, a draft strategy paper should be developed.
- Organization of a international study tour to one of the Western European countries with a sophisticated GP system (eg., the UK), to study its system, including GP education, GP functions and roles, licensing and accreditation, pattern of medical practice, and payment policies.
- Upon return from the study tour the group will finalize the strategy paper, which will then be used for policy formulation.

3) Technical assistance:

- Technical assistance will focus on facilitation and drafting of the strategy paper.

Annex 2. Health Finance Working Group

Information requirements:

There is a number of research studies that would need to be conducted to satisfy the information requirements stated in the areas of responsibilities section. The Working Group needs to specify these activities and studies as much as possible.

There are some recommended studies and activities, which could be discussed with the group:

- **National Health Accounts:** this type of study provides information about national health expenditures distributed by financing sources, financing agents, functions, regions, and population groups. It describes the way funds flow through the system. It is very useful to have a clear picture of the current system when considering a change of funds allocation mechanisms.
- **Household Survey:** this survey would investigate the socioeconomic characteristics of household members, ability to pay, household knowledge and preferences and health seeking decisions. This would provide useful information to understand the demand for health care and estimate private health spending as a share of the overall health spending.
- **Costing studies:** costing studies at both the primary care level and the hospital level could assist in pricing services in the event that provider payment methods will be changed. For example, in the consolidated vision document, Primary Care providers are expected to be paid a per-capita rate, which includes all aspects of health care provision. However, costing studies should NOT be conducted without a clear specific purpose and a clear definition of the limits of the study.
- **Link between planning and budgeting:** It is not clear how budgeting currently takes place in the MOH. An understanding of the MOH budgeting process is essential before any recommendations concerning strengthening the link between health planning and budgeting could take place.

Strategy for Implementation

A. Strategy

Implementing the Iraqi Health System Vision will be a long and difficult but empowering process. It is not yet possible to outline every step in a detailed implementation plan as the overarching framework of the constitution is not yet determined. In addition, change and reform are step-by-step processes that require constant adaptation of plans to changing environments, and to the results and lessons learned of previous steps. While it is not possible to develop a detailed implementation plan, it is possible to design a strategy for implementation to initiate and guide the process as it develops a life of its own.

A proposed strategy for implementation is to pick first steps in the change process that create the following dynamics:

- **Solid Base** -- builds a foundation and capacity for the new health system in both structure and human resource cadre.
- **Inevitable Linear Progression** -- naturally leads to other steps in the health system development process.
- **Integration** -- creates synergies and linkages between different elements of the health system.
- **Evidence** -- develops evidence of improvement that strengthens the appetite for further reform.
- **Timeframe** -- be implemented immediately to begin to bear fruit and to build confidence and hope for the future.

What should these important first steps be called? They could be called ‘triggers’, as a major reason they are selected is because they automatically trigger subsequent steps. This proposal calls them ‘seeds’ -- comparable to Iraq itself, they have faced a long winter but are now emerging into spring, and planting seeds which will bear fruit many times over in the future.

In summary, the strategy for implementation is to plant the seeds of change in 2004 and watch them grow, multiply, and bear fruit in 2005 and beyond. Proposed seeds of change described in the next section are:

1. Pooling funds and new provider payment systems;
2. Health sector institutional structure, roles, relationships and capacity building;
3. Developing a legal and regulatory framework;
4. Building Iraqi ownership; and
5. Strengthening primary health care.

Over time, the phases of implementation will need to be outlined to guide the overall development process. This strategy adopts two phases – an Initiation Phase in 2004, and a Development Phase in 2005 and beyond. A number of mechanisms for implementation will be utilized, one example is pilots where a reform can be tested and then refined before being extended to the entire country. Both the phases of implementation and the role of pilots need to be extensively discussed before finalizing the strategy for implementation.

The role of the Working Groups will need to evolve as the task moves from development of a broad vision and strategy for implementation to actual implementation. In implementation, the Iraqi health sector institutions will take the leading role in day-to-day operations. The

Working Groups must remain as an open and participatory mechanism to provide input on technical options, monitor the results of the change process, and advocate and disseminate information on health system development in Iraq. A related topic is the development of a mechanism for the MOH to coordinate donors. In 2004, the MOH may want to establish a structure and process within the MOH to ensure that all donor efforts are coordinated and integrated.

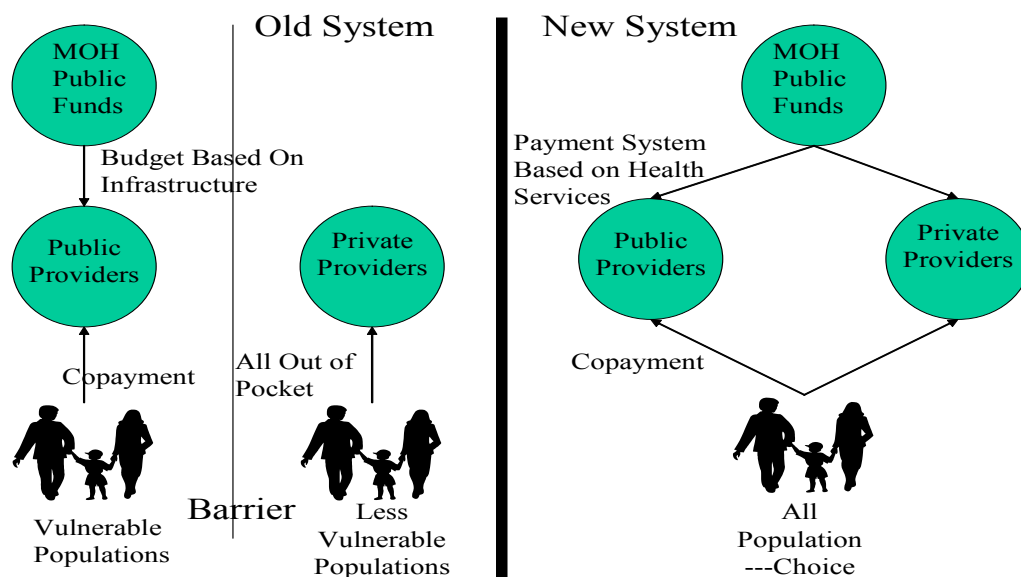
B. Seeds of Change

This section describes each seed of change, including why it meets the criteria, and proposes an initial implementation plan for 2004.

1. Pooling Funds and New Provider Payment Systems

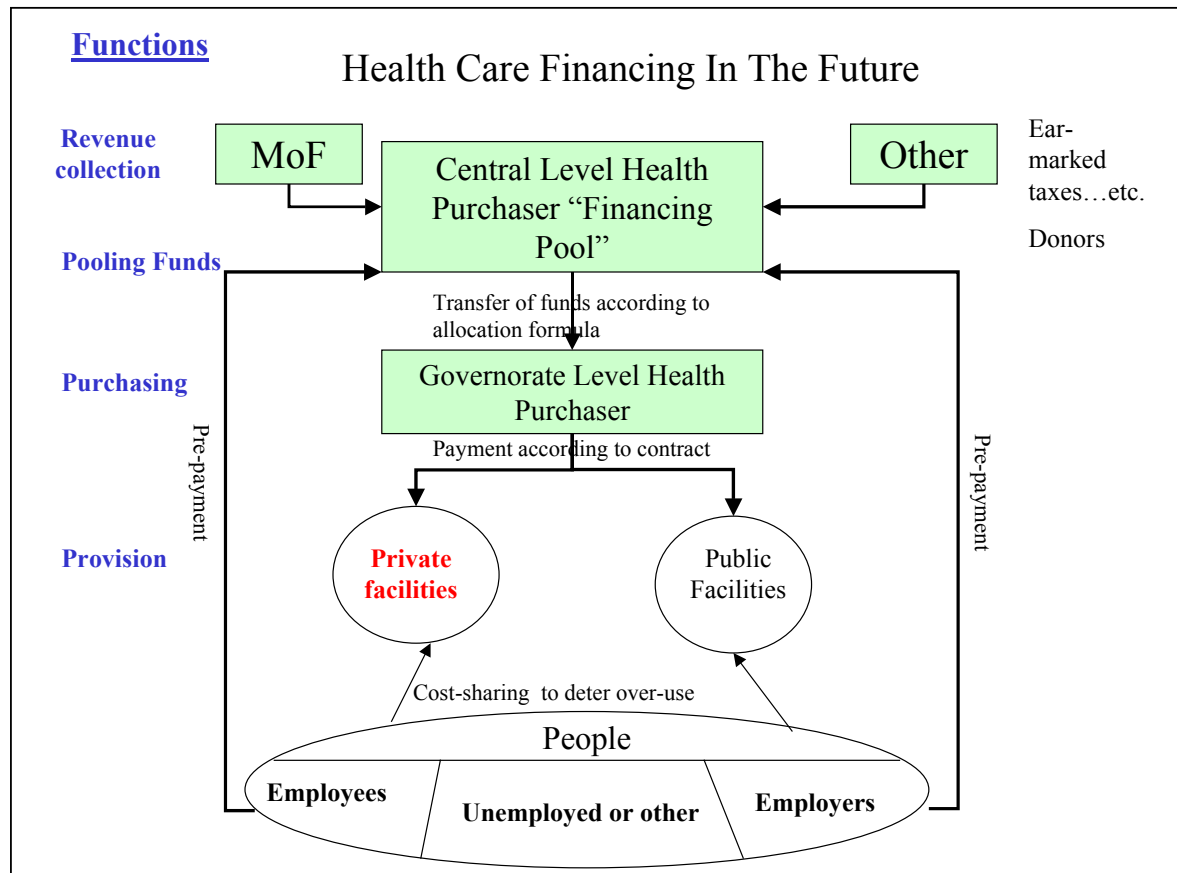
The vision sees all Iraqi citizens empowered with the choice of receiving health services in a public or private facility, and entitled to equitable coverage under a basic benefit package. Currently, the state health budget pays for only public health system infrastructure (buildings). Achieving the vision requires paying for health services in either public or private facilities rather than paying for only public health buildings. Paying for health services requires the implementation of new provider payment systems. It is a precondition for the overall vision of empowering the population with choice and the development of a blended and integrated public/private health delivery system. This dynamic is shown in the following chart.

Payment to Public and Private Providers



New provider payment systems are a seed of change because they naturally evolve or lead to other steps, such as specifying the basic benefit package. They create synergies or linkages between health financing and quality improvement and professional development, for example, establishment of accreditation or credentialing mechanisms. They build a foundation and capacity for the new health system by allowing patient choice and changing the core financial incentives leading to increased equity, efficiency, and behavior change and increased consumer responsiveness.

Two of the main pillars of the overall vision are centralized finance and decentralized management. The Health Finance Working Group vision also promotes this in their health finance functional specification, shown in the diagram below. Centralizing of financing requires pooling of all state health funding. Decentralizing of the management of health facilities can range from community ownership under community boards to more health facility autonomy to allocate resources. The links between the pool of funds and the more autonomous provider are the provider payment systems.



Specifically, this strategy for implementation proposes maintaining the decentralized management of the “auto-financing” system while centralizing financing into a state health pool of funds distributed to health providers by new provider payment systems based on patient choice. An implementation plan in 2004 and 2005 for this seed of change is outlined below.

2004:

- The MOH Finance Department functions as the health purchaser.
- State health funds from different sources are pooled in the MOH Finance Department.
- The new provider payment systems outlined below are implemented April 1st or July 1st, 2004, with quarterly refinements.
- The new provider payment systems would apply to PHC Centers and General Hospitals, as these are the core of the health delivery system.

- The health facility would receive payment from two separate pools: a salary pool with no change from planned in 2004, and an operating pool for other expenses.
- The operating pool would be converted to a new provider payment system (PPS).
- The PPS would be based on the number of people enrolled for PHC and the number of cases for inpatient or hospital care.
- For PHC, the PPS is a capitated rate → Facility Total Budget = Capitated Rate x Number of People.
- For hospitals, the PPS is case-based → Facility Total Budget = Case Rate x Number of People.
- The operating pool for the PHC and hospital payment systems includes funding for drugs. The facilities will order (purchase) drugs from Kimadia, which remains a monopoly in the short-term.
- Health providers have autonomy to allocate the resources from the operating pool capitated rate and case payments.
- Research, analysis, design, and development of systems needed for refinement in 2005 are all ongoing.

2005:

- The population can choose to receive services at both public and private facilities and explicit enrollment of the population in the PHC Center of their choice occurs.
- Pooling and provider payment systems continue and are refined.
- Other improvements could include improving the budget formation process, referral rules and incentives introduced, copayment policies revised, payment connected to accreditation or credentialing, introduction of a basic benefits package, etc.

This plan improves equity and risk protection, introduces patient choice and incentives for increased efficiency, and encourages health provider management autonomy. It could be implemented either nationally or in pilot governorates. In addition, in 2004 the MOH should continue the policy dialogue process on topics such as the dynamics of centralizing health financing functions, and decentralizing health management functions. For example, facility boards could be reinstituted and enhanced to involve the community in the provision of health services. Also in 2004, the MOH should work with the MOF to establish the principles of public expenditure management for the health sector early in the development process. Rather than determining how providers should spend their money, it would be good to initiate a process focusing on monitoring and evaluating the outcomes or quality of services provided based on objective indicators.

2. Institutional Structure, Roles, Relationships, and Capacity Building

Implementation needs implementing agents; and avoidance of confusion and conflict requires clarity of who is responsible for what. Developing a process to help ensure this clarity and transparency would include:

- Identifying all health sector functions.
- Determining what institution or entity will perform what function.
- Defining how institutions or entities relate to each other.
- Ensuring institutions or entities have the capacity to perform their functions.

Separation of functions and definition of institutional structure, roles, and relationships completely meet the criteria for a seed of change – they are the foundation or soil of the health sector and all future implementation steps require Iraqi institutions with clear roles and

relationships and the capacity to develop and manage the reform process. In the long-term, strengthening the leadership and management of the health sector requires separation of functions and alignment in a manner that promotes transparency.

While finalizing the health sector institutional structure, roles, and relationships awaits the broader political and social structure contained in the yet-to-be-developed Iraqi Constitution, some preliminary steps can be taken to maximize time and resources invested in capacity-building opportunities. In 2004, a health sector functional specification could be performed and initial reorganization of the MOH and other health sector institutions undertaken. In addition, some preliminary separation and realignment of functions could be initiated, with corresponding capacity building in these institutions. Specific MOH departments or other health sector institutions where capacity building is targeted early in the change process could include:

a. Finance

- Capacity building for the MOH Finance Department in health purchasing and implementing new provider payment systems.
- Technical assistance or training for providers to strengthen health management. In the long-term this could lead to improving undergraduate and graduate health management education.
- Establishment of a technical commission to analyze and research health financing and payment data that contribute to policy dialogue and development of technical methodologies.

b. Quality

- Capacity building for the MOH Clinical and Quality Department in policy development and management of PHC, public health, and other priority programs; and quality improvement initiatives including improvement of clinical standards or protocols.
- Strengthen the capacity of professional associations to contribute to professional development through activities such as certifying or providing continuing medical education and credentialing for health professionals.
- Establish and build capacity of an independent institution for accreditation of both public and private providers, as recommended by the Working Groups. The accreditation institution could also contain a technical commission for the development of technical standards for quality service delivery and research on quality improvement methods.

c. Human Resources

- Establish a “Health Professional Education Board” whose purpose would be to set policy for workforce supply and skill mix and accredit health professional education programs. This board would be composed of persons from MOH, MOHE, MOL, professional groups, and educational leaders.

d. Population involvement

- The rights and responsibilities of the population need to be redefined and expanded. There is a large potential role for community-based organizations (CBOs) and non-government organizations (NGOs) in health promotion. Establishing and building capacity in CBOs and NGOs will involve the population in their health, connect health to the community, advocate for consumer rights, and provide a link to the building of civil society required in the democratic transition.

3. Legal and Regulatory Framework

The development of a health sector legal and regulatory framework is a long-term and continually evolving endeavor. However, it is a seed of change as it is a precondition for most next steps, a critical part of the health sector foundation, and an important tool to link and integrate different elements of the health system. Two possible 2004 activities are outlined below:

a. Structure of the Legal and Regulatory Framework

It will be difficult to solidify the content of the legal and regulatory framework over the next year since the constitution is not yet in place. However, it would be beneficial to research international models and develop a preliminary legal and regulatory structure that can be filled-in step-by-step over time. In 2004, young lawyers affiliated with the Ministry of Justice can work with the MOH to develop the broad structure of the legal and regulatory framework, do legal research as necessary, and begin drafting some preliminary legal and regulatory documents.

b. Critical Legal Issues

There are a number of critical legal issues that need to be addressed over the next year, or time may reduce the ability of Iraq to establish a rational regulatory framework to address them. One example is regulation of the private sector. Private investment is important to the health sector, however, the private sector should develop within a legal and regulatory framework consistent with the overall vision for the health sector. How should the MOH regulate the private health sector?

Capital investment in general is another issue where the legal and regulatory framework should be decided upon relatively soon. The tenets for the vision developed in the Working Groups did not see a regulatory certificate of need process. However, they did include the MOH establishing standards and specifications for new capital investment. In 2004, the MOH should initiate the development of regulations on the standards and specifications for new capital investments. In addition, some type of simulation model could be developed to estimate the long-term cost implications for both state spending on health and total spending on health.

4. Iraqi Ownership

What is meant by Iraqi ownership is that health authorities, health professionals, and the population in all geographic locations of the country understand the vision for the future health system, understand what it means to them personally, and understand how they can contribute to the realization of the vision. It is a seed of change because without understanding and ownership of the vision it will be very difficult to move forward in implementation. While the Working Group process used to develop the draft vision was participatory, it is important that all Iraqis understand and contribute their opinions. Over the next couple of months, a process is planned that will inform and gather input from stakeholders before the “Strategic Vision” and “Strategy for Implementation” documents are finalized. Later in 2004, the participatory dialogue will continue to address specific aspects of the strategy for implementation and subsequent plans.

5. Strengthen the Foundation of Primary Health Care

In general, seeds of change are not implementing specific health programs. They are creating the dynamics of change and developing the underlying health system foundation and capacity that impact all health programs. However, strengthening primary health care is one of the major pillars of vision, and years of neglect will require substantial time and investment to remedy and improve. It is hard to invert the pyramid of the health delivery system from hospital-oriented to a primary health care orientation, and also to realign the rest of the system until primary health care is strengthened and its scope of services expanded. In addition, conversion from a medical model to a more community-oriented health model will also take time and changes in mentality. The MOH could start this process in 2004 by focusing capital investment in primary health care, providing clinical training, strengthening the connection between primary health care centers and the community, and initiating health education activities empowering the population to perform their new responsibilities.